

MATTERS ARISING

Child sexual abuse—the interface with genitourinary medicine

Whilst welcoming the increased debate about child sexual abuse (CSA) within the medical profession we were disappointed by this paper.¹ There are more data concerning CSA available in the UK than presented, including the incidence (number of new cases seen each year) and prevalence (the proportion of the population which has been sexually abused at some time during childhood).² There clearly is a disparity between the two and most child sexual abuse goes unrecognised. Recent studies suggest about 1 in 2 women and 1 in 5 men have suffered some form of sexual abuse by the time they reach adulthood, and many in childhood. Five per cent of women and 2% of men have suffered serious abuse as in rape.³

Children should be seen and examined by children's doctors with appropriate training and good links with the local genitourinary medical clinic. In Leeds we have this model and one of our genitourinary colleagues attends our monthly peer review of colposcope slides, as we have already learned from our American colleagues. A national meeting of paediatricians interested in child abuse is held quarterly; some colleagues are also police surgeons (Paediatricians Child Abuse Interest Group, affiliated to the BAACH and the British Paediatric Association).

Medical examinations of children who may have been abused are performed by an appropriately trained senior doctor (Consultant, SCMO or Senior Registrar). The advice of a police surgeon is requested as indicated, for example a stranger rape. Rogers misquoted¹ the paper prepared by the Independent Second Opinion Panel 1987⁴ which suggested "a joint examination between a paediatricians or other childrens doctor and an experienced police surgeon may be the most appropriate arrangement". As more childrens' doctors are trained the role of police surgeons is likely to diminish.

Rogers and Roberts description of medical history and physical findings in sexually abused children is confused. A good history, especially of any bowel or genitourinary disorder is needed and any physical signs interpreted in the light of the disorder, but clearly common disorders and sexual abuse may coexist. West⁵ in his helpful paper described the physical signs associated with accidental genital injury and the differentiation from CSA. Bays and Jenny⁶ discussed genital and anal conditions which may be confused with CSA.

There has been a recent useful paper on the examination of post-pubertal girls and the (nil) effect of tampon use.⁷ Paediatricians have considered that the insertion of foreign bodies in the vagina of pre-pubertal girls is highly suggestive of CSA. Herman-Giddens in a recent paper confirms this.^{8,9}

Rogers and Roberts have not quoted the literature concerning physical abuse and CSA; signs of physical assault are not

"uncommon" but seen in around 20% of children.^{10,11}

Bamford and Roberts¹² when describing the signs of intercrural intercourse wrote "The rounded labial contour may be flattened, but it is not a reliable sign . . ." In the same article the comment is made that in most young children the unstretched hymenal orifice is no more than 0.5–0.6 cm increasing slightly as puberty approaches. The RCP Report¹² states that an orifice of greater than 1 cm is not seen in normal prepubertal children. Has Dr Roberts changed her views since 1993?

Anal abuse in children has been described, and the association of genital and anal abuse.^{14,15,16} These papers are descriptive of the signs associated with abuse in English children. Rogers and Roberts are anecdotal in this paper and consequently unconvincing when reporting the signs associated with abuse without reference to the appropriate literature.

Sexually transmitted diseases are probably underdiagnosed in CSA. We found a STD in only 5%, but these were young children and most of the abuse was intra-familial. We would suggest a joint clinic with a GUM specialist may be more appropriate for teenagers. HIV infection is a complex area and we have proposed a protocol for looking at the indications for testing.¹⁷

There is a great deal of debate in the UK amongst paediatricians about CSA, but there is too little research although audit is established locally. There is an increasing literature (British as well from the US) and practitioners need to use this to inform their practice.

C J HOBBS

J M WYNNE

Community Child Health

Leeds Community & Mental Health Trust,

Belmont House,

315 Belmont Grove,

Leeds LS2 9NP, UK

Accepted for publication 27 April 1995.

1 Rogers DJ, Roberts REI. Child sexual abuse—the interface with genitourinary medicine. *Genitourin Med* 1995;71:47–52.

2 Hobbs CJ, Hanks HGL, Wynne JM. In sexual abuse, the scope of the problem. *Child Abuse and Neglect*. Edinburgh: Churchill Livingstone, 1993.

3 Kelly L, Reagan L, Burton S. An exploratory study of sex abuse in childhood in a sample of 1200 16–21 year olds. 1991, funded by European Research Council. Available Child Abuse Studies Unit, University of North London, London.

4 Kolvin I. Child sexual abuse: principles of good practice. *Br J Hosp Med* 1988;39:54–62.

5 West R, Davies D, Fenton T. Accidental vulval injuries in children. *BMJ* 1989;298:1002–3.

6 Bays J, Jenny C. Genital and anal conditions with child sexual abuse trauma. *Am J Dis Child* 1991;144:1319–22.

7 Emmans SJ, Woods ER, Alfred EN, Grace E. Hymenal findings in adolescent women: impact of tampon use and consensual sexual activity. *Pediatr* 1994;125:153–60.

8 Hobbs CJ, Wynne JM. The evaluation of child sexual abuse. In Hobbs CJ, Wynne JM, eds *Child Abuse—in Clinical Paediatrics series* 1993. Edinburgh: Balliere—Tindall.

9 Herman-Giddens ME. Vaginal foreign bodies and child sexual abuse. *Arch Pediatr Adolesc Med* 1994;148:195–200.

10 Hobbs CJ, Wynne JM. The sexually abused battered child. *Arch Dis Child* 1990;65:423–7.

11 Reinhardt MA. Sexual abuse of battered young children. *Pediatr Emerg Care* 1987;3:36–8.

12 Bamford F, Roberts R. Child Sexual Abuse. In: Meadow R. (ed). *ABC of Child Abuse*. London: British Medical Journal. 1989.

13 Royal College of Physicians. *Physical Signs of Sexual Abuse in Children*. 1991. London: Royal College of Physicians.

14 Hobbs CJ, Wynne JM. Buggery in childhood—a common syndrome of child abuse. *Lancet* 1986;ii:792–6.

15 Hobbs CJ, Wynne JM. Child sexual abuse—an increasing rate of diagnosis. *Lancet* 1987;ii:837–41.

16 Hobbs CJ, Wynne JM. Sexual abuse of English boys and girls: the importance of anal examination. *Child Abuse Negl* 1989;13:195.

17 Hobbs CJ, Wynne JM. *HIV infection in Child Abuse and Neglect* 1993. Edinburgh: Churchill Livingstone.

Rogers and Roberts reply:

Our article is based on our own experience of examining large numbers of children, giving expert evidence in court in many parts of the country for the Crown Prosecution Service, defence solicitors and Local Authorities, seeing many case records and reports by other doctors and a very careful review of the world literature.

Between us, we have spent a considerable time with Professor John McCann (refs 36, 53) and Dr. Astrid Heger (refs 42, 46), both of whom visited the UK and held workshops in the Yorkshire area to which Drs Hobbs and Wynne were personally invited and chose not to attend, though other paediatricians did.

Their letter refers to seven of their own publications, several of which refer to the same group of patients, some of whom were diagnosed as having been sexually abused on criteria (such as the occurrence of anal dilatation in the presence of stool) which are not now generally accepted as being reliable.

One author has personal knowledge that many of these children have not been found by the courts to have been abused, and some have not even been placed on an "at risk" register.¹

For these reasons, papers by Hobbs and Wynne were not included in our extensive list of references.

Their response to our article illustrates only too clearly the problems in the UK which sadly do not assist the welfare of children and which appall our American and Australian colleagues.

There should be a national peer review forum open to all doctors working in the field who are prepared to learn from their mistakes and move forward in the interests of children.

It is hoped that such a forum will shortly be set up under the auspices of the Royal Society of Medicine.

DEBORAH J ROGERS
RAINE EI ROBERTS

1 Frothingham TE, Barnett RAM, Hobbs CJ, Wynne JM. Child Sexual Abuse in Leeds, Before and After Cleveland. *Child Abuse Review* 1993;2:23–34.

Family planning in genitourinary medicine

The recent papers by Masters *et al* and Carlin *et al* highlighted the need for and the benefit of providing contraception within a genitourinary medicine (GUM) clinic.^{1,2} Unlike an "opportunistic" service, setting up a designated family planning (FP) clinic can be difficult without adequate resources, in particular funding, as commented by Carlin *et al*. However, an alternate option may be the integration of the local FP service in the

GUM clinic as experienced in our department, especially as FP practitioners have been promoting the need for collaboration between the two specialities to provide a comprehensive sexual health service for women.³

At the request of the GUM consultant, nearly a decade ago, Wandsworth Family Planning Services established a FP clinic in the GUM department. This arrangement has not required any additional funding from GUM, simply the provision of, initially one, now two female consultation and examination rooms one morning a week and the cooperation of the clerical staff and nurses. The FP doctors and nurse, employed by Wandsworth Health Authority, have had training in GUM and can therefore provide screening for sexually transmitted diseases (STDs) using the GUM laboratory facilities. Wandsworth Family Planning Services also fund the contraceptives provided.

This setup has been mutually beneficial and a recent evaluation is awaiting publication. In general, referrals from GUM include: clients requiring contraception and opting for an on-site service, in particular HIV seropositive women; post coital contraception follow ups; fittings for an intra-uterine contraceptive device (IUCD) if indicated for emergency contraception and follow up of women treated for a pelvic infection who have an IUCD. Conversely, the community based FP services use this clinic as a tertiary referral centre, particularly for patients who require an STD screen, such as women on the combined oral contraceptive pill who complain of breakthrough bleeding that may be due to infection or hormonal problems, patients with inflammatory cervical smears and/or smears identifying a genital infection, women who request or clinically require an STD screen before insertion of an IUCD and those with IUCD related problems, such as bleeding, pelvic pain and *Actinomyces israelii* infection.

This designated clinic has other advantages. It maintains the confidentiality sought by GUM patients, especially for HIV seropositive women for whom confidentiality is such an important issue; it attracts patients from the local FP services who require an STD screen and are too embarrassed to attend a routine GUM clinic and the FP team can avail of the resources of the health advisors for tracing contacts of patients identified with a sexual infection or counselling of patients requesting an HIV test. Furthermore, this clinic is ideal for teaching purposes. It provides on-site training of GUM doctors and nurses in family planning and training for FP doctors for the IUCD letter of competence. FP doctors and nurses in the community are also encouraged to sit in on routine GUM clinics. This increases awareness among staff of the importance of collaboration between the two specialities.

One measure of the clinic's success has been the need to expand the service as, initially only one FP doctor, now two, and still the appointments are fully booked six weeks in advance. Together with Wandsworth Community Health Trust there are plans to extend the service to three sessions a week, to include the one tertiary referral FP clinic and two other standard FP clinics, when the GUM department is relocated to a new purpose-built building at the end of this year and can therefore provide more clinic space.

In conclusion, the integration of FP services within GUM with staff trained in both specialities is an alternative, cost-effective, mutually beneficial, means of providing coordinated sexual health clinic for women combining contraceptive provision with STD/HIV/cervical cytology screening.

NM DESMOND
EAF DAVIDSON
Department of Genitourinary Medicine,
St George's Hospital
PS OAKELEY
Family Planning Services,
Tooting Health Clinic

Address for correspondence: Dr NM Desmond,
Department of Genitourinary Medicine, St.
George's Hospital, Blackshaw Road, London
SW17 0QT, UK.

- 1 Masters L, Nicholas H, Bunting P, Welch J. Family planning in genitourinary medicine: an opportunistic service? *Genitourin Med* 1995;71:103-5.
- 2 Carlin EM, Russell JM, Sibley K, Boag FC. Evaluating a designated family planning clinic within a genitourinary medicine clinic. *Genitourin Med* 1995;71:106-8.
- 3 Stedman Y, Elstein M. Rethinking sexual health clinics. *BMJ* 1995;310:342-3.

Rectal gonorrhoea as an independent risk factor for HIV infection in homosexual males

We read with interest the recent study by Craib and colleagues¹ which demonstrated an association between HIV seroconversion and rectal gonorrhoea in homosexual men. Because of the shared risks of sexual behaviour for both conditions² and methodological problems it has not been possible to show that the relationship between sexually transmitted diseases (STDs) and HIV transmission is causal although this is believed to be the case.³ We studied the association between non-ulcerative STDs and HIV seroconversion retrospectively in homosexual men attending the Department of Genitourinary Medicine in Bristol and our findings are in agreement with Craib and colleagues and add further support to the belief that STDs facilitate the transmission of HIV. This has important implications for health intervention programmes in homosexual men.

All homosexual HIV antibody positive men, up to February 1994, who had had a previous negative test were identified; these were matched with controls who had had a negative test, for age and date of the case's positive test. Twenty cases and 40 controls were identified.

No information was available on frequency of anal intercourse or number of partners per year. To attempt to reduce the confounding factor of high risk sexual behaviour for both STDs and HIV we categorised sexual behaviour into higher and lower risk groups according to whether the relationship was open or closed respectively. Men who had more than one sexual partner at any given time were recorded as being in an open type relationship, and men who were documented to have a (serial) monogamous relationship(s) were considered to be in a closed type relationship.

The following was recorded from the notes: age; dates of the positive and last negative test for the cases and date of test for the controls; type and number of STDs. Condom usage which was recorded as

always, sometimes or never.

The median age of cases was 26 years (range 17-37); this was not statistically different from the controls. The median test interval was 20 months (range 1-61), in the controls the mean difference from the matching test date was 5.45 months (SD 6.23).

There was shown to be no difference in incidence of hepatitis B or syphilis between the two groups. Two (10%) of 20 cases and three (7.5%) of 40 controls had had hepatitis B. One (5%) of 20 cases and no controls had had syphilis. None of the index patients acquired these infections during the study period.

To assess the role of STDs in facilitating HIV infection we considered only those which are present on the genital epithelium/mucosa that is, gonorrhoea, genital warts, genital herpes and non-specific urethritis. STDs were recorded during the study period for the index patients and for an equivalent time period for the controls. We considered all patients with no documented history of an STD infection as being "negative" and found that presence of STDs showed a significant relationship with risk of seroconversion ($p < 0.01$). Information on STDs was not available in eight of the index patients since their negative HIV test. Six (30%) of 20 cases and two (5%) of 40 controls had had at least one STD. Open relationship type also carried a significant increased risk of seroconversion ($p < 0.02$). Sixteen (80%) of 20 cases and 18 (45%) of 40 controls were in the high risk group.

In order to control for the confounding factor that males in open relationships are theoretically more likely to become infected with STDs and HIV we carried out a Mantel-Haenszel multivariate analysis. STDs were independently associated (odds ratio = 5.91 CI 1.43-24.5) with HIV seroconversion as was open type relationship (odds ratio = 8.41 CI 1.32-53.4).

Use of condoms was not statistically significant between cases and controls. Information was not available in two index patients and four controls. Of the index patients two (11%) always used condoms, three (17%) sometimes and 13 (72%) never used them compared with three (8.3%), six (17%) and 27 (75%) respectively of the controls.

Whilst this is a retrospective study and the low use of condoms might not reflect current sexual behaviour there is evidence that risk behaviour among young homosexual men is still high despite on-going HIV prevention programmes.⁴ New approaches are therefore urgently needed. Much interest is currently focused on the prevention, treatment and control of STDs as a means of reducing HIV transmission in heterosexual populations from the developing world. Our findings support the conclusion of Craib and colleagues that health intervention programmes are needed which are designed to control gonorrhoea. In addition they suggest that these programmes should also be directed at other STDs. This study provides support for the continued development and expansion of such programmes in all sexually active individuals.

SASHA BURN
Bristol University Medical School,
Dolphin House,
Bristol Royal Infirmary,
Bristol BS2 8HW
PATRICK J HORNER
Department of Genitourinary Medicine,
Bristol Royal Infirmary,
Bristol BS2 8HW